

PLAN OF CARE / COST COMPARISON BUDGET FOR THE AUTISM WAIVER

State Form 46020 (R3 / 11-96) HCBS 1B / 2B Approved by State Board of Accounts, 1994

PLEASE FILL FORM OUT COMPLETELY.

This state agency is requesting disclousure of your Social Security number in order to expedite processing of your Plan of Care. Disclosure is voluntary and you will not be penalized for failure to disclose SSN per IC -4-1-8.

CENTRAL OFFICE USE ONLY					
OMPP	Date	Initials			
MWU	Date	Initials			
Retuned	Date	Initials			

☐ Initial Plan of Care ☐ Re-Entry - Previous Termi	ination Date			_ 🗆 ι	Jpdate Plar	n of Care	Annual Plan of Care
Last name		First na	ame				Middle initial
Address (number, street)							
City, state, ZIP code						Date of birth	
Medicaid number	1 1	1	1 1			Medicaid eligibilit	y date
Social Security number					Area agen	cy number	BDDS number
Level of care (please check one)	Level of	care - c	urrent approval o	late		Level of care - pr	 evious approval date
Level of oure (please around the)	2000101	oaic o	arrent approvar c	Julio		Level of date pr	evious approvar date
□ P □ Q	Date:				Date:		
Diagnosis 1	From 450B		Diagnosis 2				From 450B
START DATE WAIVER EFFECTIVE DATE:			MEDICAID F DISCHARG				
Recommendation							
Plan of care - effective from			to				
A. He	OME AND CO	MMIINI	ITV - BASED (APE CO	nete .		
Plan of care information:	OWIL AND CO	VIIVIOIN	III - DAGED (JAIL CO	3313		
a. Case management (1/4	hr) Unite auth / i	mo	v I Init co	et ¢		- Mo. cost	¢
b. Case management assessment							\$
c. Respite Care / Home Health Aide(1 hr							
/ LPN (1 hr							·
/ RN (1 h							
/ IDDARS - ILS (1/2							
							\$
							\$
f. Habilitation	,						•
Group(1/4	hr.) Units auth. / i	mo.	x Unit co	st \$		= Mo. cost	\$
Individual (1/4	•						
Behavior Management(1/4							
Res. Based Hab / ADL(1/4							
Supported Employment(1/4	•						
Pre-Voc(1/4							
Transportation - 1 way trip(1/4	•						
g. Crisis Intervention (1/2							
g. Onsis intervention(1/2	iii.) Oilits autii. 7		X OIIII 00	σιψ		= 1010. 0031	Ψ
Case Management Agency			Total A.	.1 - Waiver	r Service C	osts \$	
Case Manager I.D. Number (4 digits)	1 1	ı	Total A.	2 - Other	Medicaid C	cost \$	
Case Manager Authorization Number (9 digits)		<u>'</u>	Total A.	. 5 - HCBS	Cost	\$	
	<u> </u>		Total B.	.7 - Facility	y Cost Fact	or \$	

Date budget was completed

2.		OTHER MEDICAID SER	VICES		
a. Physician		3 mo. payment history \$	÷	3 = Estimated mo. cost	
b. Pharmacy		3 mo. payment history \$	÷	3 = Estimated mo. cost	
c. Therapy		3 mo. payment history \$	÷	3 = Estimated mo. cost	
d. Lab / X - ray _		3 mo. payment history \$	÷	3 = Estimated mo. cost	
e. Supplies		3 mo. payment history \$	÷	3 = Estimated mo. cost	
f. Durable medical	equipment	3 mo. payment history \$	÷	3 = Estimated mo. cost	
g. Transportation		3 mo. payment history \$	÷	3 = Estimated mo. cost	
h. Other:		3 mo. payment history \$	÷	3 = Estimated mo. cost	
i. Other:		3 mo. payment history \$	÷	3 = Estimated mo. cost	
		3 mo. payment history \$			
				A.2 - Other Medicaid Cost	
				\$	
3. Total of lines	A.1 \$	A.2 \$	= \$		A.3
4 Minus Recipien	t Spend-Down Amount		- \$		
4. miliao reolpien	t opena bown Amount		Ψ		A.4
	Community Care Costs	ICE / MD INICTITUTIONAL /	= \$		A.5
B.		ICF / MR INSTITUTIONAL (JUS 13		
1. ICF / MR per die	em \$ x 30 d	ays	= \$_		B.1
2. Other Medicaid	l services:				
a. Physician		3 mo. payment history \$	÷	3 = Estimated mo. cost	
b. Pharmacy _		3 mo. payment history \$	÷	3 = Estimated mo. cost	
c. Therapy		_ 3 mo. payment history \$	÷	3 = Estimated mo. cost	
d. Lab / X - ray		_ 3 mo. payment history \$	÷	- 3 = Estimated mo. cost	
e. Supplies		_ 3 mo. payment history \$	÷	- 3 = Estimated mo. cost	
f. Durable medic	al equipment	_ 3 mo. payment history \$	÷	- 3 = Estimated mo. cost	
g. Transportation		_ 3 mo. payment history \$	÷	3 = Estimated mo. cost	
h. Other:		3 mo. payment history \$	÷	- 3 = Estimated mo. cost	
i. Other:		3 mo. payment history \$	÷	- 3 = Estimated mo. cost	
j. Other:		3 mo. payment history \$		3 = Estimated mo. cost	
			Total	B.2 - Other Medicaid Cost	
				\$	
3. Total of lines	B.1 \$	B.2 \$	= \$		B.3
4. Minus Recipien	t Liability Reduction		- \$		B.4
5. Total ICF / MR Costs			= \$		B.5
				.90	
6. Waiver Program Factor			Х	.50	B.6
7. ICF / MR Cost Factor			= \$		B.7

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C. DOCUMENTATION OF PAYMENT HISTORY - Indicate source(s) and dates of information used to determine cost reported in section A.2.						
D.	NON-REIMBURSED CAREGIVE	R				
Туре	Provider - specify name and address	Telephone r	number	Frequency		
PRIMARY	Name			NA		
CAREGIVER	Address			NA .		
E.	DESCRIPTION					
	how the Plan of Care provides adequate coverage to ensure the health and welfare (s) for the change(s).	of the waiver recipier	nt. For Update Pla	an of Care,		
E	COST COMPARISON DETERMINA	TION				
	rison Data indicates:					
a. If line A.5 \$ _	is LESS THAN line B.7 \$, then the recipient is ELIGIE must be offered the choice of ICF / MR Institutional Care or Home and Community-B	BLE for Home and Co	ommunity-Based	Waiver		
	is ELIGIBLE for Home and Community-Based Waiver Services.	asca Octvices.				
IXeoplent	is Eligible for notifie and Community-Dased Walver Gervices.					
	assed Waiver Services.	NOT BE ELIGIBLE	for Home and			
Recipient may NOT BE ELIGIBLE for Home and Community-Based Waiver Services.						
2. Request for	approval to exceed calculations:					
a. Monthly amo	unt which exceeds institutional cost factor: \$					
b. Duration of excess costs:						
	y determination to exceed cost:					
Approved Denied Signature of Authorized Waiver Unit Date						
Signature of Aut	norized Waiver Unit	Dat	te			
G. FREEDOM OF CHOICE						
A Medicaid Waiver Services case manager has explained the array of services available to meet my needs through the Medicaid Home and Community - Based Services Waiver. I have been fully informed of the services available to me in an ICF / MR institutional setting. I understand the alternatives available and have been given the opportunity to choose between waiver services and institutional care. As long as I remain eligible for waiver services, I will continue to have the opportunity to choose between waiver services and institutional care.						
1. Choice of Waiver Services:						
At this time, I have chosen to receive waiver services in a home and community-based setting, rather than in an institutional setting.						
Signature of Red	cipient / Guardian		Date			
2. Choice of Institutional Services:						
At this time, I have chosen to receive services in an institutional setting, rather than in a home and community-based setting.						
Signature of Red	cipient / Guardian		Date			

H.	CHOICE OF PROVIDERS	
If the receipient chooses to receive waiver services, they have	the right to select any approved waiver service p	provider(s).
I have been informed of my right ot choose any certified was Signature of Recipient / Guardian	Biver service provider when selecting waiver serv	
Signature of Recipient / Guardian		Date
 I.	ERGENCY BACKUP PLANS	
Describe how medical needs, supervision, behavior issues, etc.,		
Describe now medical needs, supervision, behavior issues, etc.,	will be covered dailing all emergency.	
J.	NOTES	
Include documentation of any unmet needs.	NOTES	
involute documentation of any uniner needs.		
v l		
K.	SIGNATURES	Data
Signature of Case Manager	Case Manager's I.D. number	Date
	CV PLAN OF CARE RETERMINATION	
•	CY PLAN OF CARE DETERMINATION	Data
Signature of Authorized Wa	iver unit kepresentative	Date
Approved Disapproved		